Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005010	A. BUILDING: _____ B. WING _____	07/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOSPITAL & HEALTH CENTER INC	1907 W SYCAMORE ST KOKOMO, IN 46904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 005010 Type of Survey: State Licensure Off Site JCAHO Accreditation Survey Date of JCAHO On Site Survey - Hospital full survey 7/15-18/2014 Date of ISDH off site review - 9/15/2014 Reviewer/Surveyor -Nancy Otten, RN, PHNS Based on review of the July/2014 JCAHO Accreditation Survey Report, it has been determined that St Joseph Hospital and Health Center meets the requirements for Hospital Licensure in Indiana for 2014.	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE